Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, INFUSION CENTER

Defaults for orders not otherwise specified below:
- ☐ Interval: Once
- ☐ Interval: Every _____ days
- ☐ Interval: PRN every _____ days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Appointment Requests

☑ Initial Appointment Request (Infusion)
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

☑ PRN Subsequent Appointment Request (Infusion) – FOR PRN ORDERS ONLY
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Ordering Guidelines

☑ ONC PROVIDER REMINDER 4
When ordering hydration orders for outpatient infusion DO NOT CHANGE the MEDICATION FREQUENCY field to anything other than Continuous, ONCE or PRN. The MEDICATION FREQUENCY is how the patient will receive that medication during the visit.

If you would like the patient to come in on a schedule FOR REPEATED TREATEMENT, you should update the INTERVAL in the Therapy plan. This can be done by opening up the medication order and using ORDER SCHEDULE (blue background at top of medication order) and update the INTERVAL.

Nursing Orders

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

☑ ONC NURSING COMMUNICATION 101 – **FOR BARIATRIC HYDRATIONS ONLY**
Following are OK to have after surgery:
- Protein shakes
- Sugar free jello
- Sugar free popsicles
- Broth
- Water
- Non-carbonated, caffeine free, < 15 cal beverages
-

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Hydration - Intermittent infusion/Bolus

☐ sodium chloride 0.9% bolus injection 1,000 mL

1,000 mL, Intravenous, Administer over 60 Minutes, Once, Starting S, For 1 Dose

Outpatient infusion. Maximum infusion rate 999 mL/hr. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML)

☐ lactated ringers IV Bolus 1,000 mL

1,000 mL, Intravenous, Administer over 60 Minutes, Once, Starting S, For 1 Dose

Outpatient infusion. Maximum infusion rate 999 mL/hr. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML)

☐ custom IVPB builder for fluids less than 1,000 mL

_____ mL/hr, Administer over _____ minutes, Intravenous, Once, Starting S, For 1 Dose

Base Solution

- ☐ Dextrose 5% _____ mL
- ☐ Sodium Chloride 0.9% _____ mL

Additives

- ☐ Potassium Chloride _____ mEq
- ☐ Sodium Chloride _____ mEq
- ☐ Calcium Gluconate _____ grams
- ☐ Magnesium Sulfate _____ grams
- ☐ _____

Duration

- ☐ 15 minutes
- ☐ 30 minutes
- ☐ 45 minutes
- ☐ 60 minutes

Outpatient infusion. Maximum infusion rate 999 mL/hr. If using the Custom IV builder - you should always select an additive and base. Do not use to order a plain hydration fluid. (DO NOT USE THIS ORDER IF TOTAL VOLUME OF DOSE IS GREATER THAN 1000 ML.)

Hydration - Continuous/Maintenance

☐ sodium chloride 0.9% (NS) infusion

_____ mL/hr, Administer over _____ minutes, Intravenous, Continuous, Starting S

Outpatient infusion. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

☐ lactated ringers infusion

_____ mL/hr, Administer over _____ minutes, Intravenous, Continuous, Starting S

Outpatient infusion. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

☐ custom IV infusion builder for fluids more than 1,000 mL

_____ mL/hr, Administer over _____ minutes, Intravenous, Continuous, Starting S

Base Solution

- ☐ Dextrose 5% _____ mL
- ☐ Dextrose 10% _____ mL
- ☐ Dextrose 5% and sodium chloride 0.2% _____ mL
- ☐ Dextrose 5% and sodium chloride 0.45% _____ mL
- ☐ Dextrose 5% and sodium chloride 0.9% _____ mL
- ☐ Sodium Chloride 0.9% _____ mL
- ☐ Sodium Chloride 0.45% _____ mL
- ☐ Dextrose 5% and lactated ringers _____ mL
- ☐ Lactated Ringers _____ mL

Additives

- ☐ Potassium Chloride _____ mEq
- ☐ Sodium Chloride _____ mEq
- ☐ Calcium Gluconate _____ grams
- ☐ Magnesium Sulfate _____ grams
- ☐ _____

Outpatient Infusion. If using the Custom IV builder - you should always select an additive and base. Do not use to order a plain hydration fluid. (USE FOR ANY INFUSION ORDER OVER A TOTAL OF 1000 ML OR MAINTENANCE FLUID.)

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HYDRATION WITH OPTIONAL ANTIEMETICS - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Antiemetic Therapy

☐ promethazine (PHENERGAN) in dextrose 5% 50 mL IVPB
- ☐ 12.5 mg
- ☐ 25 mg

Intravenous, Administer over 15 Minutes, Once, Starting S, For 1 Dose

☐ ondansetron HCl (ZOFRAN) in sodium chloride 0.9 % 50 mL IVPB
- ☐ 4 mg
- ☐ 8 mg
- ☐ 12 mg
- ☐ 16 mg

Intravenous, Administer over 15 Minutes, Once, Starting S, For 1 Dose

☐ dexamethasone sod phosphate (DECADRON) injection 8 mg
8 mg, Intravenous, Once, Starting S, For 1 Dose

Medications

☐ thiamine (VITAMIN B1) 100 mg in dextrose 5 % 51 mL IVPB
100 mg, Intravenous, Administer over 30 Minutes, Once, Starting S, For 1 Dose

☐ folic acid 1 mg in dextrose 5 % 100.2 mL IVPB
1 mg, Intravenous, Administer over 30 Minutes, Once, Starting S, For 1 Dose
1 mg/mL = 1,667 mcg DFE/mL (Dietary Folate Equivalents)

Additional Medications

☐ Medication with dose: _____

☐ Medication with dose: _____

Lab Orders

	Interval	Duration
☐ Lab: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐ Lab: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician Sign**